CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/30/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155072		(X2) MULTIPI A. BUILDING B. WING	LE CONSTRUCTION 00	СОМ	(X3) DATE SURVEY COMPLETED 09/09/2011	
	PROVIDER OR SUPPLIER		200	EET ADDRESS, CITY, STATE, ZII 02 ALBANY ST ECH GROVE, IN46107	P CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	CROSS-REFERENCED TO TH	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F0000	to the Recertifical completed on Au This visit was in investigation of cand IN00095409 Survey dates: Seg 2011 Facility number: Provider number AIM number: 10 Survey team: Lei Bar Patt Cour	conjunction with the complaints IN00095190 ptember 8th and 9th, 000029 155072 00275200 ia Alley, RN, TC bara Hughes, RN by Allen, BSW artney Mujic, RN Gates, BHS	F0000			
LABORATOR	Y DIRECTOR'S OR PROV	TIDER/SUPPLIER REPRESENTATIVE'S SIG	GNATURE	TITLE		(X6) DATE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

3ZFE12

Facility ID:

000029

If continuation sheet

l		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED
155072		155072	A. BUILDING B. WING		09/09/2011
	PROVIDER OR SUPPLIER		2002 AI	ADDRESS, CITY, STATE, ZIP CODE LBANY ST I GROVE, IN46107	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
		•			
F0282 SS=D	facility must be proin accordance with plan of care. Based on observative record review, the diet orders were residents in a total (Resident #17, Resident #5) Findings include 1. The clinical rewas reviewed on The diagnoses for but were not limited.	esident #117, and	F0282	F282 Services by qualified persons/per care plan. This provider ensures that service provided or arranged by the facility is provided by qualified persons in accordance with experience resident's written plan of care What corrective action(s) will accomplished for those reside found to have been affected the deficient practice. Reside that reside in the facility are risk for the deficient practice. Resident #17 diet orders were evaluated by the RD and ord was clarified per recommendations and physical No added Salt diet was discontinued. Resident #17	ed each e. I be dents by ents at . re der cian.

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/C		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPL	COMPLETED	
		155072	B. WIN			09/09/20	011
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF 1	PROVIDER OR SUPPLIEF	R		1	BANY ST		
BEECH (GROVE MEADOWS			1	GROVE, IN46107		
	GROVE WILADOWS	,			GNOVE, 114-0107		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· `	ICY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Nutrition.				diet order was reviewed by	.	
					Dietary Clinician and ordered		
	The 9/6/11 phys:	ician telephone order			clarified by recommendation		
		nt #17's diet clarification			physician. Resident now reco a NAS diet. Resident #5 die		
	was mechanical				order was reviewed by Dieta		
					Clinician and order clarified	, ,	
	1 1	AS (no added salt), nectar			recommendations and physi		
	thick liquids, and	d fortified foods.			Diet is Regular with ground r	neat.	
					How will you identify other		
	During observat	ion of Resident #17 eating			residents having the potentia		
	lunch on 9/8/11	at 1:00 p.m., she was			be affected by the same defi	cient	
	observed with an	open salt packet on her			practice and what corrective action will be taken. Reside	nte	
	tray.				that reside in the facility have		
					potential to be affected by th		
	During interview	with the RD (registered			alleged deficient practice.		
	_	· -			Residents with therapeutic d	iet	
	· · · · · · · · · · · · · · · · · · ·	/11 at 1:40 p.m., she			physician orders were reviev		
		nt #17 should not have			ensure compliance. No other		
	_	on her tray due to her			residents were identified. W		
	NAS diet.				measures will be put into pla		
					systemic changes you will m to ensure that the deficient	ake	
	2. The clinical r	ecord for Resident #117			practice does not recur. Die	tarv	
	was reviewed or	9/8/11 at 12:20 a.m.			Manager or designee will		
		. , , , , , , , , , , , , , , , , , , ,			in-service staff, to include		
	The diagnoses for	or Resident #117			department heads and nursi	ng	
	1				staff on or before September		
	1	re not limited to:			2011 regarding reading tray		
		s, Hyperlipidemia, and			and providing items as listed		
	Hypertension.				tray card. Dietary Manager designee will audit meal serv		
	The September, 2011 physician's				accuracy concerning consist		
					of meal per physician's	,	
	recapitulation or	ders indicated Resident			orders. Dietary technician		
	1 ^	consistent carbohydrate,			will audit tray cards to ensure	e they	
		salt), and low cholesterol.			match physician orders.		
		,			Department heads will doubl		
	During about	ion of Decident #117			check that the tray cards ma		
	_	ion of Resident #117			the physician orders. Nursing to be inserviced on or before		
	eating lunch in h	is room on 9/8/11 at					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIII	A. BUILDING 00		COMPLETED	
		155072	B. WIN			09/09/2	011
		<u> </u>	D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIEF	₹		1	BANY ST		
DEECH	GROVE MEADOWS			1	GROVE, IN46107		
BEEGII	GROVE WEADOW	3		BEECH	GROVE, IN40107		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	12:40 p.m., he w	as observed with a salt			9/30/11 on dietary communic		
	packet on his tra	y.			slips and ensuring the Dietar		
	1				technician receives any char	iges.	
	 During interview	w with the RD (registered			A box marked "Diet Communication Slips' will be		
	_	/11 at 1:41 p.m., she			placed outside the Dietary		
	· · · · · · · · · · · · · · · · · · ·	•			technicians office. The		
		ent #117 should not have			interdisciplinary team will rev	iew l	
	1 -	t on his tray due to his			the physician telephone orde		
	NAS diet.				Monday-Friday excluding ho		
					and weekends to monitor alt	ered	
	3 The clinical r	record for Resident #5 was			diet orders. Dietary techician		
		/11 at 12:30 p.m.			attends IDT meeting and upo		
	l cvicwed on 5/6/	11 at 12.30 p.m.			meal ticket at that time. Wee		
					manager will be responsible		
	_	or Resident #5 included,			reviewing orders and updatir		
	but were not lim	ited to: Hyponatremia,			meal tickets on the weekend		
	Hyperlipidemia,	Barrett's Esophagitis and			physician orders for altered on have been audited by Dietar		
	Hypertension.				Technician to ensure meal tid		
	J. T.				are accurate. A department h		
	The 0/6/11 phys	ician telephone order			will be assigned to every me		
	1	•			ensure compliance, weekly x		
		ent #5's diet clarification			monthly x 2. If a deficiency i		
	_	fortified foods and ice			noted, an action plan will be		
	cream at lunch a	nd dinner.			developed and implemented		
					How the corrective action(s)	will	
	During observat	ion of Resident #5 eating			be monitored to ensure the		
	1	n Dining Room on 9/8/11			deficient practice will not rec	ur,	
		•			i.e., what quality assurance program will be put into place		
		was observed eating a			tool "Meal Service Observati		
		diet consisting of ground,			will be completed by Dietary	OII	
	chopped up ham	burger.			Manager or designee weekly	/ x 4.	
					monthly x 2 and quarterly X 2		
	The 9/8/11 meal	ticket for Resident #5			deficiency is noted, an action		
	provided by the	RD (registered dietician)			will be developed and		
	1 -	p.m. indicated the diet			implemented. Dietary Manag	jer or	
		•			designee is responsible for		
	for Resident #5	was mechanical soft.			monitoring compliance. Any		
					findings will be brought to the	e QA	
	During interview	w with the RD on 9/8/11 at			team on a monthly basis.		

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155072		A. BUILDING	00	COMPLETED 09/09/2011			
	PROVIDER OR SUPPLIER		B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 2002 ALBANY ST BEECH GROVE, IN46107				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETION		
		dicated she never 11 physician ordered diet Resident #5.					
F0325 SS=D	Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem.		F0325	F325 Maintain Nutrition S Unless Unavoidable This provider ensures that resid maintain acceptable paran of nutritional status unless resident's clinical condition demonstrates that this is n possible; and receives a therapeutic diet when there nutritional problem. What corrective action(s) will be accomplished for those res found to have been affecte the deficient practice. Res that reside in the facility an risk for the deficient practic Resident #17 diet orders w evaluated by the RD and of	dents meters the n not e is a t sidents ed by sidents e at ce. vere		

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIM DDIG		00	COMPLETED	
		155072	A. BUIL			09/09/2	
		100072	B. WING				
NAME OF F	PROVIDER OR SUPPLIER			STREET A	DDRESS, CITY, STATE, ZIP CODE		
					BANY ST		
	GROVE MEADOWS	3			GROVE, IN46107		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PERCEDED BY FULL]	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	DEFICIENCY)		DATE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	was clarified per recommendations and physi No added Salt diet was discontinued. Resident # 1' diet order was reviewed by Dietary Clinician and ordered clarified by recommendation physician. Resident now recommendation and order was reviewed by Dietar Clinician and order clarified precommendations and physi Diet is Regular with ground residents having the potential be affected by the same defi practice and what corrective action will be taken. Resident treside in the facility have potential to be affected by the alleged deficient practice. Residents with therapeutic dephysician orders were reviewensure compliance. No other residents were identified. We measures will be put into plasystemic changes you will measure that the deficient practice does not recur. Die Manager or designee will in-service staff, to include department heads and nursing staff on or before September 2011 regarding reading tray and providing items as listed tray card. Dietary Manager designee will audit meal servacuracy concerning consist of meal per physician's orders. Dietary technician	d s and eiving et ry per cian. meat. al to cient et the e iet wed to r /hat ce or ake tary ng cards per or vice ency	DATE
					will audit tray cards to ensure match physician orders.	и псу	
			_				

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155072 A. BUILDING B. WING O COMPLETE 09/09/201	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
2002 ALBANY ST	
BEECH GROVE MEADOWS BEECH GROVE, IN46107	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CONSTRUCTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Department heads will double check that the tray cards match the physician orders. Nursing staff to be inserviced on or before 9/30/11 on dietary communication slips and ensuring the Dietary technician receives any changes. A box marked "Diet Communication Slips' will be placed outside the Dietary technicians office. The interdisciplinary team will review the physician telephone orders Monday-Friday excluding holidays and weekends to monitor altered diet orders. Dietary technician attends IDT meeting and updates meal ticket at that time. Weekend manager will be responsible for reviewing orders and updating of meal tickets on the weekend. All physician orders for altered diets have been audited by Dietary Technician to ansure meal tickets are accurate. A department head will be assigned to every meal, to ensure compliance, weekly x 4, monthly x 2. If a deficiency is noted, an action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place CQI tool "Meal Service Observation" will be completed by Dietary Manager or designee weekly x 2. If a deficiency is noted, an action plan will be developed and implemented. How the corrective action(s) will be completed by Dietary Manager or designee weekly x 2. If a deficiency is noted, an action plan will be developed and implemented inplemented inplemented by Dietary Manager or designee weekly x 2. If a deficiency is noted, an action plan will be developed and implemented inplemented.	DATE

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155072		IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED	
		B. WIN			09/09/2011		
			P		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER				LBANY ST		
BEECH (GROVE MEADOWS	3		I	I GROVE, IN46107		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
					designee is responsible for monitoring compliance. Any findings will be brought to the team on a monthly basis.	e QA	
	Based on observa	ation, interview, and					
	record review, th	e facility failed to ensure					
	diet orders were	followed for 3 of 14					
	residents in a total	al sample of 14.					
		esident #117, and					
	Resident #5)						
	resident may						
	Findings include	:					
	1. The clinical re	ecord for Resident #17					
	was reviewed on	9/8/11 at 11:30 a.m.					
	The diagnoses for Resident #17 included, but were not limited to: Diabetes Mellitis, Hyperlipidemia, Hypertension, and Poor Nutrition. The 9/6/11 physician telephone order indicated Resident #17's diet clarification was mechanical soft, consistent carbohydrate, NAS (no added salt), nectar						
	thick liquids, and						
	During observation of Resident #17 eating lunch on 9/8/11 at 1:00 p.m., she was observed with an open salt packet on her tray.						
	_	with the RD (registered /11 at 1:40 p.m., she					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155072		(X2) MULTIPLE CO A. BUILDING B. WING	00	li i	E SURVEY PLETED 2011	
NAME OF PROVIDER OR SUPPLIER BEECH GROVE MEADOWS			2002 AI	ADDRESS, CITY, STATE, ZIP C LBANY ST I GROVE, IN46107	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
		nt #17 should not have on her tray due to her				
		ecord for Resident #117 9/8/11 at 12:20 a.m.				
	The diagnoses for included, but we Diabetes Mellitis Hypertension.					
	#117's diet was o	2011 physician's ders indicated Resident consistent carbohydrate, salt), and low cholesterol.				
	eating lunch in h	on of Resident #117 is room on 9/8/11 at as observed with a salt y.				
	dietician) on 9/8 indicated Reside	with the RD (registered /11 at 1:41 p.m., she nt #117 should not have on his tray due to his				
	3. The clinical r reviewed on 9/8/	ecord for Resident #5 was /11 at 12:30 p.m.				
	but were not lim	or Resident #5 included, ited to: Hyponatremia, Barrett's Esophagitis and				

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DINC	00	COMPI	LETED
155072		155072	B. WIN			09/09/2	2011
			р. _{(УП}		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIE	R		1	LBANY ST		
BEECH (GROVE MEADOW	S		1	I GROVE, IN46107		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX		NCY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	1	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	DATE
	Hypertension.	,					
	Trypertension.						
	The 0/6/11 mbres	isian talanhana andan					
	1	ician telephone order					
	1	ent #5's diet clarification					
		n fortified foods and ice					
	cream at lunch a	and dinner.					
	During observat	ion of Resident #5 eating					
	lunch in the Mai	in Dining Room on 9/8/11					
	at 1:10 p.m., he	was observed eating a					
	mechanical soft	diet consisting of ground,					
	chopped up ham						
	· · · · · · · · · · · · · · · · · · ·						
	 The 9/8/11 meal	ticket for Resident #5					
		RD (registered dietician)					
	1 -	· -					
		0 p.m. indicated the diet					
	for Resident #5	was mechanical soft.					
		11 11 DD 0/0/11					
	_	w with the RD on 9/8/11 at					
		ndicated she never					
	received the 9/6	/11 physician ordered diet					
	clarification for	Resident #5.					
	3.1-46(a)(2)						
R0000							
			RO	0000			

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